S. No. 2
M—5-42
5-17-39
I X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 8 1944

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

3348

State File No.

Registration District No. 171 Primary Registration District No. 4268 Registrar's No. 1

1. PLACE OF DEATH:

(a) County LAFAYETTE
(b) City or town MAYVIEW Mo.
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community 20 YEARS
years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County LAFAYETTE
(c) City or town MAYVIEW Mo.
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country /

3. (a) PRINT FULL NAME CLAUD FAIR HOBBS

3. (b) If veteran, name war No

3. (c) Social Security No. No

4. Sex MALE

5. Color or race White

6. (a) Single, widowed, married, divorced MARRIED /

6. (b) Name of husband or wife ADDIE HOBBS

6. (c) Age of husband or wife if alive 50 years

7. Birth date of deceased July (Month) 8 (Day) 1886 (Year)

8. AGE: Years 57 Months 6 Days 14 If less than one day hr. min.

9. Birthplace ICONIUM (City, town, or county) Mo (State or foreign country) 0

10. Usual occupation BARBER

11. Industry or business

FATHER
12. Name PEITTER HOBBS
13. Birthplace STATE OF MISSOURI (City, town, or county) (State or foreign country) 0

MOTHER
14. Maiden name AUGUSTA JONES
15. Birthplace FAIRFIELD (City, town, or county) Mo (State or foreign country) 0

16. (a) Informant CLEO HOBBS
(b) Address BLUE SPRINGS Mo

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof JAN 23 1944 (Month) (Day) (Year)
(c) Place: burial or cremation HIGGINSVILLE City CEMALERY

18. (a) Signature of funeral director E. S. JAMES
(b) Address CONCORDIA Mo

19. (a) Feb-3-1944 (Date received local registrar) (b) Mrs W. F. Baker (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month JAN day 22
year 1944 hour 12 minute 10 A M.

21. I hereby certify that I attended the deceased from Jan 21 1944, to Jan 22 1944
that I last saw him alive on Jan 21 1944
and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Chronic Interstitial Nephritis developing uraemia	many years. 2 wks.
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations 131a
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury 0

23. Signature W. Kappenbrink (M. D. or other) MA
Address Higginsville Mo Date signed 1/23/1944

1101

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 2-7-44

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by me, Registered Apprentice No. , working under my personal supervision.

Signed E. S. James

Licensed Embalmer No. 2058

P. O. Address Concordia Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.